## STATE OF UTAH LABOR COMMISSION

## DIVISION OF INDUSTRIAL ACCIDENTS

P.O. BOX 146610, 160 E 300 SO, SALT LAKE CITY, UT 84114-6610 (801)530-6800 (800)530-5090 (TTD)530-7685 FAX 530-6804

## REQUEST FOR CLAIMS RESOLUTION CONFERENCE

NAME	DAME OF THIRV
	DATE OF INJURY
	PHONE NUMBER
ADDRESS	ET .
CITY, STATE,	ZTD
, ,	
	ORNEY TO ASSIST YOU WITH YOUR CLAIM ? YES NO COMMISSION NEITHER REQUIRES NOR DISCOURAGES LEGAL
	ION IN THE PURSUIT OF A WORKERS COMPENSATION CLAIM.
EMPLOYER INFORMATION	
NAME	PHONE NUMBER
ADDRESS	
STRE	ET
CITY, STAT	TE, ZIP
INSURANCE CARRIER IN	FORMATION
NAME	PHONE NUMBER
ADDRESS	ADJUSTOR
STRE	ET (IF KNOWN)
CITY, STATE,	ZIP
	ISSUES NEEDING RESOLUTION:
L	
3.	
- If	more room is needed, please use the back of this form
I REQUEST TO H	AVE A CLAIMS RESOLUTION CONFERENCE SCHEDULED TO RESOLVE THE ABOVE ISSUES.
REQUESTOR'S SIGNATURE _	PHONE NUMBERDATE
	_ Employee Adjustor Applicant's Counsel Defense Counsel Other (Please specify)
Your Claims Resolution Co Industrial Accidents receive	onference will be scheduled within 14 days from the time the Division of es agreement from both parties to participate in this process.
CASE NUMBER	